The PRESIDING OFFICER. The Senator from California is recognized, but the Senator doesn't have any time.

Mrs. BOXER. Mr. President, I ask unanimous consent that I may use 5 minutes of Senator DURBIN's time, to be followed by Senator GRAHAM and then Senator DORGAN.

The PRESIDING OFFICER. Without objection, it is so ordered.

CLINTON-GORE PRESCRIPTION DRUG PLAN

Mrs. BOXER. Mr. President, I thank my colleague for giving me these 5 minutes. I listened to Senator GRAMM's attack on the Clinton-Gore prescription drug plan, the Democratic plan. I will tell you, it was very interesting because I just read an article in one of the newspapers. I think it was in The Hill. It is an article by Representative SHERROD BROWN. Representative BROWN points to a confidential document—I will quote him—prepared for House Republicans. It found its way into the public realm. It wasn't news at the time, he says, but when you read it, it suggests that the Republicans go after the Democratic plan by calling it a one-size-fits-all plan, ''a big government plan, especially a one-size-fits-all big government plan.''

As I listened to Senator GRAMM, he uses those terms over and over again. Now it sort of makes sense as to why they have put out this strategy on how to attack this plan. I had to smile when I was listening to Senator GRAMM because I thought, Is he attacking the Medicare program? The Medicare program is a program that covers 99 percent of our seniors. I suppose he thinks that the one-size-fits-all big government plan—and I assume he feels that way because Governor Bush, in 4 years, wants to do away with the Medicare plan. So this is what is happening here.

I want to share a couple of charts that show the differences between the two plans. This is amazing. Also, they say it is a forced plan when it is voluntary. Vice President GORE has been very clear that the plan is a voluntary plan. Seniors can take it if they want. So here you have the Democratic plan, which is affordable for all seniors. It is part of Medicare and it is voluntary. It has a defined benefit, and it gives bargaining power to seniors so that the cost of the drugs would go down.

The House Republican bill has no assistance to seniors with incomes over $12,500. So that leaves out most seniors. It is private insurance, not Medicare. Insurers say they won't offer it. We have proof of that and we have quotes. An insurer can modify or drop benefits year to year. Seniors may lose access to local pharmacies or drugs. There is no guarantee of better prices. Let's see the comments about the Bush-Republican plan—the GOP prescription drug plan by health insurers.

> We continue to believe the concept of the so-called drug-only private insurance simply would not work in practice.

That is Charles Kahn, President of the Health Insurance Association of America.

Let's look at other comments of health insurers on the GOP plan endorsed by Senator GRAMM and Governor Bush.

> Private drug insurance policies are doomed from the start. The idea sounds good, but it cannot succeed in the real world. I don't know of an insurance company that would offer a drug-only policy like that or even consider it.

Charles Kahn, President of the Health Insurance Association of America.

Health insurers tell us that the Bush Republican plan is doomed because no insurance companies are going to do it.

Here is Cecil Bykerk, Executive Vice President of the Mutual of Omaha companies, who says:

> I am convinced that stand-alone drug policies won't work.

You have a real plan by AL GORE for voluntary benefits under Medicare—a program that is revered by seniors. The fact is that the Republican plan, by the very companies that are making life miserable for seniors—HMOs, insurance companies, and pharmaceutical companies—is a complete sham.

Things are getting hot around here. It is ''happy season.'' It is political season. I think we have to get back to reality.

Let's realize that the words used by my friend, Senator GRAMM from Texas, come straight out of the Republican campaign strategy book—call it big government, call it one size fits all; if you don't like the Medicare program, then you ought to support Governor Bush's plan because in 4 years he does away with Medicare.

Let's take a look at this one more time.

The Senate Democratic bill, which is essentially the Gore plan, is affordable for all seniors. It is voluntary. It will work.

The House Republican plan and the one that is discussed by PHIL GRAMM is a sham. The insurance companies say they can't do it.

Thank you very much. I thank my colleague from Florida for allowing me to go ahead.

The PRESIDING OFFICER. The Senator from Florida is recognized.

MEDICARE REFORM

Mr. GRAHAM. Mr. President, for the past 3 days I have been discussing the need to reform Medicare and the fundamental reform of shifting Medicare from being a program that focuses on sickness and dealing with disease and the consequences of accidents after they happen, to a health care system that focuses on wellness and maintaining the highest possible quality of life. I pointed out that an essential ingredient of any wellness strategy is prescription drugs. Prescription drugs are a modality in virtually every form of therapy which is designed to reverse disease conditions or to manage those conditions.

Yesterday, I talked about the fact that the prescription drug benefit for senior Americans should be provided through the Medicare program. It is the program which the seniors themselves have indicated over and over that they believe in, they trust, they have confidence in, and that they would like it to be the program through which this additional benefit would be added to all the other benefits that are available through Medicare. They would also like prescription drugs to be available through Medicare.

In the context of the discussion of our colleague from California, I must point out that while the seniors are saying they want to have a prescription drug benefit administered through Medicare, the Governors of the States are saying they do not want to have the responsibility for administering a prescription drug benefit; it is not our job nor should it be our financial responsibility to be involved in prescription drugs for a group of Americans who have since 1965 been covered by a national program and not a State-by-State program.

I would like to talk about the issue of cost and which alternative before us has the best opportunity to serve not only the interests of the 39 million seniors but all Americans in terms of injecting some control over an out-of-control, spiraling increase in the cost of pharmaceutical drugs.

Let me use as an illustration what has happened to a constituent of mine, Mrs. Elaine Kett. Mrs. Kett is a 77-year-old widow from Vero Beach, FL. She lives on a fixed income of approximately $20,000 a year, which means that her income is above the level that would provide benefits for her under the kind of plan that my Teutonic cousin from Texas has indicated he would support.

Like many of my constituents, Mrs. Kett sent me a list of all the prescription drugs that her physician has indicated are medically necessary for her wellness and quality of life. These are the lists of Mrs. Elaine Kett's drugs. As you will see when you add up all the costs of the drugs which she used in 1999, the total cost was $10,053.36. Mrs. Kett has already said her income is $20,000 a year. Fifty cents out of every dollar of Mrs. Kett's income was consumed in paying for the prescription drugs necessary for her life, wellness, and quality.

In her letter, Mrs. Kett writes:

> This is killing me because my income is just a bit more than double the cost of these drugs.

Then she adds a postscript.

P.S.—Someone said these are the golden years, only the gold is going into someone else's pocket.

There are millions of Americans just like Mrs. Kett. Passing a real prescription drug benefit to cover Mrs. Kett and all Medicare beneficiaries should be a priority for this session of the Congress.

Today, we will examine one of the key reasons why so many seniors are unable to purchase the medications which their physicians have said are medically necessary. The reason is cost.

Prescription drug prices are growing so quickly that seniors and, I would argue, most Americans cannot keep up. In July, Families USA released a report that concluded:

The growing reliance on prescription drugs by the elderly and the mounting costs of those drugs is a crisis for America's senior citizens.

The elderly already pay a significant portion of prescription drugs expenditures out of their pockets. Today, many seniors are without any prescription drug coverage.

The traditional ways in which seniors have been covered for prescription drugs—which have included employers who provided those benefits to their retirees through the Medicaid program if they were medically indigent or through Medigap policies if they could afford the often exorbitant costs, and through HMOs which provided prescription drugs as a benefit—are constricting in terms of who they will cover and what they will cover.

So every week, more seniors are placed in the position of either having to cover their entire prescription drug costs or a larger proportion of that cost.

Today, almost one out of three seniors lacks any prescription drug coverage. Over 50 percent of Medicare beneficiaries lack coverage at some point during any given year. For those fortunate enough to have prescription drug coverage, the coverage is diminishing.

Thus, unless seniors are assured of prescription drug coverage through Medicare, many will find that needed medications are unavailable.

If it is true that the lack of prescription drug coverage has reached a crisis level for seniors, then why have we not yet enacted a real, affordable, and comprehensive prescription drug benefit under Medicare?

The answer, I suspect, includes the fact that the pharmaceutical companies may have erected an effective blockade to the enactment of a prescription drug benefit through Medicare.

In fact, the watchdog group, ''Public Citizen,'' reports that drug companies spent $83.6 million in lobbying costs this year alone.

I would suspect from looking at the television ads run by the industry that much of those moneys have been spent on lobbying efforts against the passage of a universal, affordable Medicare prescription drug benefit.

Why do the pharmaceutical companies cringe at a Medicare prescription drug proposal? It is because they know the power of the marketplace. As long as 39 million senior Americans have to deal, one by one, and as long as almost one-third of those have to deal without any assistance from any other source in the purchase of their prescription drugs, the market will not function. There is no effective purchaser-seller relationship.

What we do know is that when there is an effective market, prices can be restrained. We know it through the Veterans' Administration, which is able to purchase the exact same prescription drugs Mrs. Kett has been purchasing, but at substantially lower prices because they are using the power of a large purchaser for the benefit of American veterans. State Medicaid programs know this because they are using the power of their large purchases for the benefit of the million medically indigent within their States. HMOs know the power of the marketplace because they purchase their prescription drugs on a wholesale basis and then share those benefits with HMO beneficiaries.

With or without the support of the pharmaceutical companies, we must seek relief for seniors who are the victims of this crisis. The cost of prescription drugs is skyrocketing. We owe it to our seniors to examine the reasons and then to act.

In 1999, the prices of the 50 prescription drugs most used by older Americans increased 2 to 3 times the rate of overall inflation. In 1 year, the 50 most used prescription drugs by American seniors increased by 2 to 3 times the rate of overall inflation.

The numbers speak for themselves: Lorazepam, used to treat conditions including anxiety, convulsions, and Parkinson's disease, rose by 409 percent, 27 times the rate of inflation, from January 1994 through January 2000. Imdur, a drug used to treat angina, rose eight times the rate of inflation. And Lanoxin, used to treat congestive heart failure, rose at six times the rate of inflation.

Not only are the prices of drugs escalating at a rapid pace in the United States, but prices charged to Americans are also flat out incomprehensible.

We have all heard that prices of prescription drugs in other countries—including our neighbors, Canada and Mexico—are generally substantially lower than prices in the United States. The heartburn medicine Prilosec, the world's best seller, the largest selling prescription drug, costs $3.30 per pill in the United States. What is the price in Canada? One dollar and forty-seven cents. The allergy drug Claritin costs almost $2 a pill in the United States. What does it cost elsewhere? Forty-one cents in Great Britain and 48 cents in Australia. We are talking about exactly the same drug produced by the same manufacturer.

A constituent from Springhill, FL, called my office yesterday demanding to know why drug prices are so much lower in Mexico and Canada than they are in his hometown. I can't answer that question. Frankly, I don't think anyone can answer that question. Pharmaceutical manufacturers have been the top-ranked U.S. industry for profits as a percentage of revenue throughout the past decade. After-tax profits for the pharmaceutical industry average 17 percent of sales. By way of comparison, the average for all industries was 5 percent. The effective tax rate for the pharmaceutical industry is 16 percent. The effective tax rate for all manufacturing companies is 23 percent; 31 percent for wholesale and retail trade, financial services, and insurance and real estate, and an average of 27 percent for all industry.

While millions of seniors are sacrificing their last dollar, as is Mrs. Kett, to pay for medication, the pharmaceutical manufacturers are taking in higher profits than any other industry in the United States of America.

Money does not take precedence over health. Profits cannot be the top priority when public health is compromised. We have that responsibility as the representative of those Americans to take action.

One of the things we ought to do in addition to adding prescription drugs as a part of Medicaid is to assure public access to true drug prices as opposed to the mythic average wholesale price. This would be one step to encourage accountability among drug manufacturers. Rapidly escalating prices and inequitable prices across borders warrant an investigation and consideration of prescription drug costs containment.

I submit that by having Medicare as a new force in the marketplace, not through regulation or cost control but by using the principles of Adam Smith in a capitalist society, that with an effective purchaser of drugs for our 39 million seniors, we can see a substantial reduction in the price of pharmaceuticals for them, and all Americans will indirectly benefit. As public servants, we have a fundamental responsibility to protect all of our citizens.

We all recognize that millions of seniors in America are struggling to pay for prescription drugs, so it seems clear our goal in the Senate should be to assure that our prescription drug benefit for seniors and people with disabilities is included in Medicare.

Our proposal is that Medicare would utilize an intermediary referred to as a

''pharmacy benefit manager.'' There would be two or more of these managers in each region of the country. They would be the ones responsible for negotiating with the pharmaceutical companies and then passing on those benefits to the ultimate senior user. We cannot achieve these kinds of benefits through the fractured plan that relies upon private insurance. We cannot assure these benefits by a plan which is fractured through 50 States. We can only assure to our seniors the benefits of effective control by the marketplace if we place this plan within the Medicare program.

I appreciate the opportunity to share these remarks and look forward to a further discussion of prescription drug prices that we face in this Nation.

The PRESIDING OFFICER (Mr. HUTCHINSON). The Senator from North Dakota.

PRESCRIPTION DRUGS COST TOO MUCH

Mr. DORGAN. Mr. President, I want to talk today about the issue of prescription drugs. Some of my colleagues have already talked about this issue at some length. Let me add to that.

In January of this year, on a cold, snowy day, a group of North Dakota senior citizens and I drove from North Dakota to Canada. It was not much of a drive, as a matter of fact, from Pembina, ND, to Emerson, Canada. We went to Canada to allow these senior citizens to purchase prescription drugs in Emerson, because the same drug that is marketed in Canada—in the same bottle, made by the same company—is sold in most cases for a fraction of the price for which it is sold in the United States.

I want to illustrate that, if I may. I ask unanimous consent to use, on the floor of the Senate, two pill bottles. These bottles are for a medicine called Zocor.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. DORGAN. The bottles are slightly different, one is bigger than the other, but Zocor is sold both in Canada and the United States. Zocor is one of a number of cholesterol-lowering drugs. In fact, Dan Reeves, coach of the Atlanta Falcons, has an advertisement saying he takes a similar drug to lower his cholesterol following some heart problems he had.

In any event, Zocor is an FDA-approved drug produced by the same company, often in the same FDA-approved plant. Yet, this bottle of Zocor is sold in Winnipeg, Canada, for $1.82 per caplet. But if you are an American who is using Zocor to lower your cholesterol, you pay $3.82 per tablet. Again, if you buy it in Canada, it is $1.82 per tablet. But in the United States, the same tablet, by the same company, is not $1.82, but $3.82.

The Senate just finished yesterday a debate about normal trade relations. This used to be called most-favored-nation status. Do you know what the situation is with respect to prescription drug prices? We have least-favored-customer status for the American consumer. Why do I say this? Because prescription drug prices here are higher than anywhere else in the world. Why should the American consumer pay prices that are 10 times, or 5 times, or triple or double the price paid by everyone else in the world for the same prescription drugs made in the same plants by the same companies?

The answer is that U.S. consumers should not be least favored consumers as they are forced to be by the pharmaceutical drug industry. We can change that. How can we change it? We can change it by allowing our pharmacists and our distributors to be able to access the same FDA-approved prescription drug in Canada or in other countries—sold by the same company and produced in an FDA-inspected plant—at a lower price and pass the savings along to their customers. If we did that, the pharmaceutical industry would be required to reprice their prescription drugs in this country and reduce their prices.

I want to talk about Sylvia Miller. Sylvia Miller is one of the senior citizens who went to Canada with me. She is from Fargo, ND. A columnist in Fargo wrote a piece about Sylvia Miller. Let me just acquaint you with Sylvia Miller by reading from this piece:

> Sylvia Miller isn't one to complain, but few people would blame her if she chose to complain just a little bit. . . . Sylvia knows that life isn't always easy, that people struggle with the lows and look forward to the highs. . . . She's had her share of dark days in her 70 years of life on this earth.
>
> The 1980s were a pretty rough decade for her. She beat breast cancer in 1981, then lung cancer eight years later. She's a tough lady.

This article says she and her husband lived most of their lives in Durbin and then moved to Fargo in 1987, after ''we were flooded out by water coming cross country—the basement filled up nearly to the ceiling.''

Sylvia went with me to Emerson, Canada, 5 miles across the border, because she wanted to buy her prescription drugs at a better price. This article says Sylvia is a pleasant person. I know that because I know Sylvia. It also says she leads a disciplined life. She has to. She has diabetes. She also has asthma, and she has a heart that could be stronger. She tests her blood sugar level several times a day, eats wisely and at the right times, and the article goes on to say she gives herself shots four times a day, mixing three different insulins, uses two different inhalers for lungs which function below normal capacity, and she requires seven different prescription drugs every month. Last year, she received $4,700 from Social Security, and her prescription drug bill was more than $4,900. She says: Things don't quite add up, do they?

On our trip to Canada, I stood with Sylvia and the others in this little one-room drugstore in Emerson, Canada. The exact same prescription drugs you can buy in this tiny drugstore are sold 5 miles south, in Pembina, ND, or 120 miles south in Fargo, ND. The difference is not in the pill—it is the same pill, same color, same shape, made in the same plant, marketed by the same company. The difference? Price. Americans are the least favored consumers. They pay the highest prices.

So a group of senior citizens who pay too much for prescription drugs—such as Sylvia, who gets $4,700 on Social Security and has a $4,900 prescription drug bill—are trying to get a better price for the drugs they need to lead a good life by traveling to Canada.

These senior citizens should not have to load up in a van on a cold winter morning and drive to Canada. The Customs Service will allow individuals to bring back from Canada a small amount of prescription drugs for their personal use. But there is a Federal law that says a pharmacist from Grand Forks, ND, or Montana or Vermont, can't go to Canada and access that same drug and come back and pass the savings along to their customers. Federal law says you can't do that. We aim to change that Federal law.

The Senate has already passed our proposal. Senator JEFFORDS, Senator GORTON, Senator WELLSTONE and I, and a range of others have worked to pass this plan in the Senate. Our proposal says: Let's allow U.S. pharmacists and distributors to go to other countries and access the identical prescription drugs, approved by the FDA, at a lower price, bring them back, and pass the savings along to the American consumer. Of course, if we get this plan signed into law, what will happen is that the pharmaceutical industry will be required to reprice these drugs in this country.

Now, guess what. The pharmaceutical industry is spending a fortune to try to defeat this proposal. It is in a conference committee. I am one of the conferees. The conference isn't even meeting. Why isn't it meeting? Because people have heartburn over this proposal, and they want to kill it.

The pharmaceutical industry said the 11 former Food and Drug Administration Commissioners have come out in opposition to the proposal. Well, yesterday, I showed a letter that we received from David Kessler, the former Commissioner of the Food and Drug Administration under Presidents Bush and Clinton. I want to tell my colleagues what he says:

> The Senate bill which allows only the importation of FDA approved drugs, manufactured in approved FDA facilities, and for which the chain of custody has been maintained, addresses my fundamental concerns.